806 KAR 17:370. Standardized health claim attachments.

RELATES TO: KRS 304.17A-005, 304.17A-700-304.17A-730, 304.17C-010, 304.17C-090, 304.39-010-304.39-340, 2008 Acts ch. 127, Part XII, secs 18-20, 42 C.F.R. 411.32, 441.203, 441.206, 441.207, 441.208, 441.250, 441.255, 441.256, 441.258

STATUTORY AUTHORITY: KRS 304.2-110(1), 304.17A-720(1)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 304.2-110(1) authorizes the executive director to promulgate reasonable administrative regulations necessary for or as an aid to the effectuation of any provision of the Kentucky Insurance Code as defined in KRS 304.1-010. KRS 304.17A-720(1) requires the department to promulgate administrative regulations prescribing standardized health claim attachments to be used by insurers. EO 2008-507, effective June 16, 2008, established the Department of Insurance and the Commissioner of Insurance as head of the department. This administrative regulation establishes requirements for standardized health claim attachments and minimum requirements for routinely requested medical information health claim attachments.

Section 1. Definitions. (1) "Clean claim" is defined in KRS 304.17A-700(3).

(2) "Health benefit plan" is defined in KRS 304.17A-005(22).

(3) "Health care provider" or "provider" is defined in KRS 304.17A-700(9), as amended by 2008 Ky Acts ch. 127, Part XII, sec. 18.

(4)"Health claim attachments" is defined in KRS 304.17A-700(10).

(5) "Insurer" is defined in KRS 304.17A-005(27).

(6) "Limited health services benefit plan" is defined by KRS 304.17C-010(5).

(7) "Practitioner" means an individual licensed or certified to provide a health care service in Kentucky.

(8) "Reparation obligor" is defined in KRS 304.39-020(13).

Section 2. Standardized Health Claim Attachments. If another payment source is identified by a provider, an insurer shall require the provider to include the following health claim attachments, as applicable, for a claim to qualify as a clean claim:

(1) An explanation of benefits statement or noncoverage notice from another payer;

(2) An electronic or paper-based Medicare remittance notice if the claim involved Medicare as a payer; and

(3) A record of all payments by a reparations obligor pursuant to KRS 304.39-010 to 304.39-340.

Section 3. Routinely-requested Health Claim Attachments. An insurer offering a health benefit plan or a limited health service benefit plan for dental only, may routinely request the following health claim attachments in accordance with KRS 304.17A-706(2), as applicable:

(1) A certification of medical necessity;

(2) A complete medical record, or part of a medical record, including:

(a) Discharge summary:

1. Patient identification, including name, age, gender, and medical record number;
2. Name of attending practitioner;
3. Dates of admission and discharge;
4. Final diagnosis;
5. Reason for the admission or visit;
6. Medical history;
7. Significant findings during length of stay or visit;

8. Procedures and treatments;
9. Patient condition at discharge;
10. Discharge medications; and
11. Discharge instructions;
(b) Emergency department report:
1. Patient identification, including name, age, gender, and medical record number;
2. Date of service;
3. Attending practitioner;
4. Chief complaint and symptoms;
5. History of present illness and physical exam;
6. Diagnostic test findings;
7. Clinical impression and diagnosis;
8. Treatment plan;
9. Discharge instructions; and
10. Practitioner orders;
(c) History and physical:
1. Patient identification, including name, age, gender, and medical record number;
2. Chief complaint;
3. Details of present illness;
4. Relevant past, social and family histories;
5. Inventory by body system;
6. Summary of psychological needs;
7. Report of relevant physical exam;
8. Statement relating to the conclusions or impressions drawn from the admission history and physical;
9. Statement relating to the course of action planned for this episode of care; and
10. Name of practitioner performing history and physical;
(d) Nurse's notes:
1. Patient identification, including name, age, gender, and medical record number;
2. Vital signs with graphics, if available;
3. Intake and output record, if applicable;
4. Medication administration records;
5. Date of nurse's notes;
6. Nurse assessment;
7. Nursing intervention;
8. Observation; and
9. Name of nurse;
(e) Operative report:
1. Patient identification, including name, age, gender, and medical record number;
2. Date of procedure;
3. Operating practitioner;
4. Pre- and post-operative diagnoses;
5. List of procedures performed;
6. Operative description including indications and findings;
7. Anesthesia used; and
8. Specimens collected;
(f) Progress notes:
1. Patient identification, including name, age, gender, and medical record number;
2. Discharge or treatment plan;

3. Practitioner orders;
4. Practitioner notes;
5. Attending practitioner name;
6. Results of tests and treatments;
7. Dates of notes; and
8. Chief complaint;
(g) Test results:
1. Patient identification, including name, age, gender, and medical record number;
2. Test findings, including date ordered and date competed; and
3. Ordering practitioner name;
(h) Practitioner orders or treatment plan, as applicable:
1. Patient identification, including name, age, gender, and medical record number;
2. Practitioner orders;
3. Ordering practitioner name; and
4. Order dates;
(i) Practitioner notes:
1. Patient identification, including name, age, gender, and medical record number;
2. Practitioner name;
3. Practitioner notes; and
4. Dates of notes;
(j) Consult notes and reports:
1. Patient identification, including name, age, gender, and medical record number;
2. Practitioner name;
3. Findings and recommendations including notes and reports; and
4. Dates of notes and reports;
(k) Anesthesia record:
1. Patient identification, including name, age, gender, and medical record number;
2. Administering practitioner name;
3. Start and stop anesthesia times;
4. Route of administration;
5. Dates;
6. Notes;
7. Patient vital signs; and
8. Drug administered;
(l) Therapy notes:
1. Patient identification, including name, age, gender, and medical record number;
2. Practitioner name;
3. Practitioner orders;
4. Treatment plan;
5. Number of treatments and dates;
6. Therapist’s notes; and
7. Dates of notes;
(m) Office notes:
1. Patient identification, including name, age, gender, and medical record number;
2. Practitioner name;
3. Any notes generated for dates of service; and
4. Dates of notes;
(n) Dental records; and
(o) Pharmacy records;

(3) Certification and documentation as identified in 42 C.F.R. 441.203, 441.206, 441.207, 441.208, 441.250, 441.255, 441.256, and 441.258;

(4) Itemized bill; and

(5) Evidence of Medicare secondary payment pursuant to 42 C.F.R. 411.32. (29 Ky.R. 2399; Am. 2890; eff. 6-16-2003; TAm eff. 8-9-2007; 35 Ky.R. 413; eff. 10-31-2008.)